FOR OHF USE

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2004 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2004)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

| I. IDPH Facility ID Number: | 0041632 | | | II. CERTI | FICATION BY AUTHORIZED FACILITY OFFICER |
|---|----------------|--|---------------------|--------------------------------|--|
| Address: 1501 Canal | | Beardstown City | 62618 Zip Code | and cer are true applica | re examined the contents of the accompanying report to the fillinois, for the period from 01/01/2004 to 12/31/2004 tify to the best of my knowledge and belief that the said contents e, accurate and complete statements in accordance with ble instructions. Declaration of preparer (other than provider) d on all information of which preparer has any knowledge. |
| IDPA ID Number: | 370909086016 | | | | ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment. |
| Date of Initial License for C Type of Ownership: | urrent Owners: | 05/01/96 | | Officer or Administrator | (Signed) (Date) ((Type or Print Name) Craig L. Ater |
| VOLUNTARY,NON Charitable Co | l | PROPRIETARY Individual | VERNMENTAL State | of Provider | (Title) Senior V.P. and Chief Financial Officer |
| Trust IRS Exemption Code | | Partnership Corporation | County Other | | (Signed) (Date) |
| | | xx "Sub-S" Corp. Limited Liability Co. Trust Other | - | Paid Preparer | (Print Name and Title) (Firm Name & Address) |
| In the event there are furthe Name: | | t, please contact: one Number: <u>(</u>) | | | (Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 |

STATE OF ILLINOIS Page 2

| Facility Name & ID Nu | ımber Heritage M | anor East-Beardstowi | n | | | # 0041632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004 |
|-----------------------|---------------------------|-------------------------|---------------------|------------------------|----|--|
| III. STATISTI | CAL DATA | | | | | D. How many bed-hold days during this year were paid by Public Aid? |
| A. Licensu | re/certification level(s) | of care; enter number | of beds/bed days, | | | (Do not include bed-hold days in Section B.) |
| (must ag | ree with license). Date o | of change in licensed b | eds | | _ | |
| | | | | | | E. List all services provided by your facility for non-patients. |
| 1 | : | 2 | 3 | 4 | | (E.g., day care, "meals on wheels", outpatient therapy) |
| | | | | | | None |
| Beds at | | | | Licensed | | |
| Beginning of | Licens | ure | Beds at End of | Bed Days During | | F. Does the facility maintain a daily midnight census? <u>yes</u> |
| Report Period | Level of | f Care | Report Period | Report Period | | |
| | | | | | | G. Do pages 3 & 4 include expenses for services or |
| 1 | 71 Skilled (SN | | 71 | 25,986 | 1 | investments not directly related to patient care? |
| 2 | | diatric (SNF/PED) | | | 2 | YES NO xx |
| 3 | Intermedia | · / | | | 3 | |
| 4 | Intermedia | | | | 4 | H. Does the BALANCE SHEET (page 17) reflect any non-care assets? |
| 5 | Sheltered (| ` / | | | 5 | YES NO xx |
| 6 | ICF/DD 16 | or Less | | | 6 | I. On what date did you start providing long term care at this location? |
| 7 | 71 TOTALS | | 71 | 25,986 | 7 | Date started 05/01/96 |
| 7 | /I IOTALS | | /1 | 23,760 | / | Date started 03/01/70 |
| | | | | | | J. Was the facility purchased or leased after January 1, 1978? |
| B. Census- | For the entire report pe | eriod. | | | | YES Date NO xx |
| 1 | 2 | 3 | 4 | 5 | | |
| Level of Care | Patient Day | s by Level of Care and | d Primary Source of | Payment | | K. Was the facility certified for Medicare during the reporting year? |
| | Public Aid | | | 1 | | YES xx NO If YES, enter number |
| | Recipient | Private Pay | Other | Total | | of beds certified and days of care provided 1,588 |
| 8 SNF | 15,617 | 3,056 | 1,588 | 20,261 | 8 | |
| 9 SNF/PED | | | 0 | | 9 | Medicare Intermediary Mutual of Omaha |
| 10 ICF | | | | | 10 | |
| 11 ICF/DD | | | | | 11 | IV. ACCOUNTING BASIS |
| 12 SC | 0 | 0 | 0 | | 12 | MODIFIED |
| 13 DD 16 OR LESS | | | | | 13 | ACCRUAL XX CASH* CASH* |
| 14 TOTALS | 15,617 | 3,056 | 1,588 | 20,261 | 14 | Is your fiscal year identical to your tax year? YES xx NO |
| C. Percent | Occupancy. (Column 5 | , line 14 divided by to | tal licensed | | | Tax Year: Fiscal Year: |
| | s on line 7, column 4.) | 77.97% | <u>-</u> | | | * All facilities other than governmental must report on the accrual basis. |
| | | | | | | |

| STA | TE | OF | ш | INOIS |
|-----|----|----|---|-------|

Page 3 12/31/2004 # 0041632 Facility Name & ID Number Heritage Manor East-Beardstown **Report Period Beginning:** 01/01/2004 **Ending:**

| | V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar) | | | | | | | | | | | |
|-----|---|-------------|-----------------|---------|-----------|-----------|--------------|-----------|-----------|---------|----------|-----|
| | | | osts Per Genera | - 0 | | Reclass- | Reclassified | Adjust- | Adjusted | FOR OHF | USE ONLY | |
| | Operating Expenses | Salary/Wage | Supplies | Other | Total | ification | Total | ments | Total | | | |
| | A. General Services | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 1 | Dietary | 110,016 | 6,509 | | 116,525 | | 116,525 | 2,651 | 119,176 | | | 1 |
| 2 | Food Purchase | | 93,340 | | 93,340 | | 93,340 | | 93,340 | | | 2 |
| 3 | Housekeeping | 53,519 | 8,142 | | 61,661 | | 61,661 | | 61,661 | | | 3 |
| 4 | Laundry | 21,870 | 10,793 | | 32,663 | | 32,663 | | 32,663 | | | 4 |
| 5 | Heat and Other Utilities | | | 52,733 | 52,733 | | 52,733 | 812 | 53,545 | | | 5 |
| 6 | Maintenance | 25,580 | 23,284 | 18,995 | 67,859 | | 67,859 | 9,509 | 77,368 | | | 6 |
| 7 | Other (specify):* | | | | | | | | | | | 7 |
| 8 | TOTAL General Services | 210,985 | 142,068 | 71,728 | 424,781 | | 424,781 | 12,972 | 437,753 | | | 8 |
| | B. Health Care and Programs | | | | | | | | | | | |
| 9 | Medical Director | | | 500 | 500 | | 500 | | 500 | | | 9 |
| 10 | Nursing and Medical Records | 706,347 | 43,564 | 18,432 | 768,343 | | 768,343 | | 768,343 | | | 10 |
| 10a | | | 106,914 | 78,904 | 185,818 | (321,860) | (136,042) | 205,779 | 69,737 | | | 10a |
| 11 | Activities | 29,111 | 1,656 | | 30,767 | | 30,767 | | 30,767 | | | 11 |
| 12 | Social Services | 11,782 | | 2,544 | 14,326 | | 14,326 | | 14,326 | | | 12 |
| 13 | Nurse Aide Training | 941 | 383 | | 1,324 | | 1,324 | 1,404 | 2,728 | | | 13 |
| 14 | Program Transportation | | | | | | | | | | | 14 |
| 15 | Other (specify):* | | | | | | | | | | | 15 |
| 16 | TOTAL Health Care and Programs | 748,181 | 152,517 | 100,380 | 1,001,078 | (321,860) | 679,218 | 207,183 | 886,401 | | | 16 |
| | C. General Administration | | | | | | | | | | | |
| 17 | Administrative | 56,810 | | | 56,810 | | 56,810 | 47,735 | 104,545 | | | 17 |
| 18 | Directors Fees | | | | | | | 3,860 | 3,860 | | | 18 |
| 19 | Professional Services | | | 137,885 | 137,885 | | 137,885 | (125,749) | 12,136 | | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 55,175 | 55,175 | (40,077) | 15,098 | (6,695) | 8,403 | | | 20 |
| 21 | Clerical & General Office Expenses | 49,143 | 4,768 | 15,584 | 69,495 | | 69,495 | 96,090 | 165,585 | | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 197,325 | 197,325 | | 197,325 | 24,752 | 222,077 | | | 22 |
| 23 | Inservice Training & Education | | | 590 | 590 | | 590 | 392 | 982 | | | 23 |
| 24 | Travel and Seminar | | | 5,111 | 5,111 | | 5,111 | (3,112) | 1,999 | | | 24 |
| 25 | Other Admin. Staff Transportation | | | | İ | | | | | | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 43,727 | 43,727 | | 43,727 | 1,449 | 45,176 | | | 26 |
| 27 | Other (specify):* | | | 23,800 | 23,800 | | 23,800 | (23,800) | | | | 27 |
| 28 | TOTAL General Administration | 105,953 | 4,768 | 479,197 | 589,918 | (40,077) | 549,841 | 14,922 | 564,763 | | | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8, 16 & 28) | 1,065,119 | 299,353 | 651,305 | 2,015,777 | (361,937) | 1,653,840 | 235,077 | 1,888,917 | | | 29 |

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0041632

Report Period Beginning:

01/01/2004 Ending:

Page 4 12/31/2004

V. COST CENTER EXPENSES (continued)

| | | | Cost Per General Ledger | | | | Reclassified | Adjust- | Adjusted | FOR OHE | USE ONLY | T |
|----|------------------------------------|-------------|-------------------------|---------|-----------|-----------|--------------|---------|-----------|---------|----------|----|
| | Capital Expense | Salary/Wage | Supplies | Other | Total | ification | Total | ments | Total | | | |
| | D. Ownership | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 30 | Depreciation | | | 88,309 | 88,309 | | 88,309 | 8,254 | 96,563 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | | | | | | | | | 31 |
| 32 | Interest | | | 56,763 | 56,763 | | 56,763 | (23) | 56,740 | | | 32 |
| 33 | Real Estate Taxes | | | 23,697 | 23,697 | | 23,697 | | 23,697 | | | 33 |
| 34 | Rent-Facility & Grounds | | | | | | | 4,699 | 4,699 | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 2,833 | 2,833 | | 2,833 | 1,457 | 4,290 | | | 35 |
| 36 | Other (specify):* | | | | | | | | | | | 36 |
| 37 | TOTAL Ownership | | | 171,602 | 171,602 | | 171,602 | 14,387 | 185,989 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | | | | | | | 38 |
| 39 | Ancillary Service Centers | | | | | 321,860 | 321,860 | | 321,860 | | | 39 |
| 40 | Barber and Beauty Shops | | | | | | | | | | | 40 |
| 41 | Coffee and Gift Shops | | | | | | | | | | | 41 |
| 42 | Provider Participation Fee | | | | | 40,077 | 40,077 | | 40,077 | | | 42 |
| 43 | Other (specify):* | | | | | | | | | | | 43 |
| 44 | TOTAL Special Cost Centers | | | | | 361,937 | 361,937 | | 361,937 | | | 44 |
| | GRAND TOTAL COST | | | | | | | | | | | |
| 45 | (sum of lines 29, 37 & 44) | 1,065,119 | 299,353 | 822,907 | 2,187,379 | | 2,187,379 | 249,464 | 2,436,843 | | | 45 |

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor East-Beardstown

0041632

Report Period Beginning:

01/01/2004

Ending:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

| 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 | | NON-ALLOWABLE EXPENSES | 1 Amount | 2 Refer- ence | OHF USE ONLY | |
|--|----|--|-------------|---------------------|-----------------|----|
| 3 Governmental Sponsored Special Programs 3 4 Non-Patient Meals 4 Non-Patient Meals 4 5 Telephone, TV & Radio in Resident Rooms (393) 35 5 5 6 Rented Facility Space 34 6 6 7 Sale of Supplies to Non-Patients 7 7 8 Laundry for Non-Patients 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation 30 9 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 Owner or Key-Man Insurance 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 Land Penalties 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 Property Replacement Tax 26 Property Replacement Tax 27 Property Replacement Tax 28 29 Other-Attach Schedule 29 29 Other-Attach Schedule 29 20 25 20 25 25 Other-Attach Schedule 29 20 25 20 25 26 26 27 28 28 29 Other-Attach Schedule 29 20 20 20 20 20 20 20 | | | \$ | | \$ | |
| 4 Non-Patient Meals 4 5 Telephone, TV & Radio in Resident Rooms (393) 35 5 6 Rented Facility Space 34 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation 30 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 11 12 Non-Working Officer's or Owner's Salary 12 13 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 18 19 Entertainment (8,913) 24 19 20 Contributions (800 | 2 | | | | | |
| 5 Telephone, TV & Radio in Resident Rooms (393) 35 5 6 Rented Facility Space 34 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation 30 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 11 12 Non-Working Officer's or Owner's Salary 12 13 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties (8,913) 24 19 19 Entertainment (8,913) 24 19 20 Contributions (800) < | _ | | | | | |
| 6 Rented Facility Space 34 6 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation 30 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 11 12 Non-Working Officer's or Owner's Salary 12 13 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Momer's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties (17 18 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 23 | 4 | Tion Turion Tiens | | | | |
| 7 Sale of Supplies to Non-Patients 7 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation 30 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 111 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Interest 32 14 15 Non-Care Related Fees 12 16 16 Personal Expenses (Including Transportation) 24 16 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 20 21 Owner or Key-Man Insurance 21 22 3 Malpractice Insurance for Individuals 23 24 23 24 24 | 5 | | (393) | 35 | | 5 |
| 8 Laundry for Non-Patients 8 9 Non-Straightline Depreciation 30 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 3pecial Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 24 24 <td>6</td> <td>Rented Facility Space</td> <td></td> <td>34</td> <td></td> <td>6</td> | 6 | Rented Facility Space | | 34 | | 6 |
| 9 Non-Straightline Depreciation 30 9 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 <td>7</td> <td>Sale of Supplies to Non-Patients</td> <td></td> <td></td> <td></td> <td>7</td> | 7 | Sale of Supplies to Non-Patients | | | | 7 |
| 10 Interest and Other Investment Income (23) 32 10 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 8 | Laundry for Non-Patients | | | | 8 |
| 11 Discounts, Allowances, Rebates & Refunds 11 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 24 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 9 | Non-Straightline Depreciation | | 30 | | 9 |
| 12 Non-Working Officer's or Owner's Salary 12 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 | 10 | Interest and Other Investment Income | (23) | 32 | | 10 |
| 13 Sales Tax 2 13 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 11 | | | | | 11 |
| 14 Non-Care Related Interest 32 14 15 Non-Care Related Owner's Transactions 33 15 16 Personal Expenses (Including Transportation) 24 16 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 12 | Non-Working Officer's or Owner's Salary | | | | 12 |
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| 17 Non-Care Related Fees (1,107) 20 17 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 27 Nurse Aide Training for Non-Employees 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 15 | Non-Care Related Owner's Transactions | | 33 | | 15 |
| 18 Fines and Penalties 18 19 Entertainment (8,913) 24 19 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 16 | Personal Expenses (Including Transportation) | | 24 | | 16 |
| 19 Entertainment | 17 | Non-Care Related Fees | (1,107) | 20 | | 17 |
| 20 Contributions (800) 27 20 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 18 | Fines and Penalties | | | | 18 |
| 21 Owner or Key-Man Insurance 21 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 19 | Entertainment | (8,913) | 24 | | 19 |
| 22 Special Legal Fees & Legal Retainers (703) 19 22 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 20 | Contributions | (800) | 27 | | 20 |
| 23 Malpractice Insurance for Individuals 23 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional Income Taxes and Illinois Personal (8,197) 20 25 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 21 | Owner or Key-Man Insurance | | | | 21 |
| 24 Bad Debt (23,000) 27 24 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 22 | Special Legal Fees & Legal Retainers | (703) | 19 | | 22 |
| 25 Fund Raising, Advertising and Promotional (8,197) 20 25 Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | | | , , , | | | 23 |
| Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 24 | | (23,000) | 27 | | 24 |
| Income Taxes and Illinois Personal 26 Property Replacement Tax 26 27 Nurse Aide Training for Non-Employees 27 28 Yellow Page Advertising 28 29 Other-Attach Schedule 29 | 25 | Fund Raising, Advertising and Promotional | (8,197) | 20 | | 25 |
| 27Nurse Aide Training for Non-Employees2728Yellow Page Advertising2829Other-Attach Schedule29 | | Income Taxes and Illinois Personal | | | | |
| 28Yellow Page Advertising2829Other-Attach Schedule29 | | | | | | |
| 29 Other-Attach Schedule 29 | | | | | | 27 |
| | | | | | | |
| 30 SUBTOTAL (A): (Sum of lines 1-29) \$ (43,136) \$ 30 | | | | | | |
| | 30 | SUBTOTAL (A): (Sum of lines 1-29) | \$ (43,136) | | \$ | 30 |

| | OHF USE ONL | Y | | | | |
|----|-------------|----|----|----|----|--|
| 48 | | 49 | 50 | 51 | 52 | |
| | | | | | | |

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

| | | 1 | 2 |
|----|--------------------------------------|------------|-----------|
| | | Amount | Reference |
| 31 | Non-Paid Workers-Attach Schedule* | \$ | 31 |
| 32 | Donated Goods-Attach Schedule* | | 32 |
| | Amortization of Organization & | | |
| 33 | Pre-Operating Expense | | 33 |
| | Adjustments for Related Organization | | |
| 34 | Costs (Schedule VII) | 292,600 | 34 |
| | Other- Attach Schedule | | 35 |
| 36 | SUBTOTAL (B): (sum of lines 31-35) | \$ 292,600 | 36 |
| | (sum of SUBTOTALS | | |
| 37 | TOTAL ADJUSTMENTS (A) and (B)) | \$ 249,464 | 37 |

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions)

1 2 3

| (Se | e instructions.) | 1 | 2 | 3 | 4 | |
|-----|---------------------------------|-----|----|--------|-----------|----|
| | | Yes | No | Amount | Reference | |
| 38 | Medically Necessary Transport. | | | \$ | | 38 |
| 39 | | | | | | 39 |
| 40 | Gift and Coffee Shops | | | | | 40 |
| 41 | Barber and Beauty Shops | | | | | 41 |
| 42 | Laboratory and Radiology | | | | | 42 |
| 43 | Prescription Drugs | | | | | 43 |
| 44 | Exceptional Care Program | | | | | 44 |
| 45 | Other-Attach Schedule | | | | | 45 |
| 46 | Other-Attach Schedule | | | | | 46 |
| 47 | TOTAL (C): (sum of lines 38-46) | | | \$ | | 47 |

Page 5A

Heritage Manor East-Beardstown

| ID# | 0041632 | Report Period Beginning: | 01/01/2004 | Ending: | 12/31/2004

Sch. V Line

| | | | | Sch. V Line | |
|----|------------------------|----|----------|-------------|----|
| | NON-ALLOWABLE EXPENSES | | Amount | Reference | |
| 1 | | \$ | | | 1 |
| 2 | | | | | 2 |
| 3 | | | | | 3 |
| | | | | | |
| 4 | | | | | 4 |
| 5 | | | (393) | 35 | 5 |
| 6 | | | 0 | 34 | 6 |
| 7 | | | | | 7 |
| 8 | | | | | 8 |
| 9 | | | 0 | 30 | 9 |
| 10 | | | | 32 | 10 |
| 11 | | | | 32 | 11 |
| | | | | | |
| 12 | | | | | 12 |
| 13 | | | 0 | 2 | 13 |
| 14 | | | | 32 | 14 |
| 15 | | | 0 | 33 | 15 |
| 16 | | | | 24 | 16 |
| 17 | | | (1,107) | 20 | 17 |
| 18 | | | (-,, | | 18 |
| - | | | | 24 | |
| 19 | | | (000) | 24 | 19 |
| 20 | | | (800) | 27 | 20 |
| 21 | | | | | 21 |
| 22 | | | (703) | 19 | 22 |
| 23 | | | | | 23 |
| 24 | | | (23,000) | 27 | 24 |
| 25 | | | (8,197) | 20 | 25 |
| 26 | | | (0,) | | 26 |
| 27 | | | | | 27 |
| _ | | | | | |
| 28 | | | | | 28 |
| 29 | | | | | 29 |
| 30 | | | | | 30 |
| 31 | | | | | 31 |
| 32 | | | | | 32 |
| 33 | | | | | 33 |
| 34 | | | | | 34 |
| 35 | | | | | 35 |
| 36 | | | | | 36 |
| | | | | | |
| 37 | | | | | 37 |
| 38 | | | | | 38 |
| 39 | | | | | 39 |
| 40 | | | | | 40 |
| 41 | | | | | 41 |
| 42 | | | | | 42 |
| 43 | | - | | | 43 |
| 44 | | - | | | 44 |
| | | | | | |
| 45 | | | | | 45 |
| 46 | | | | | 46 |
| 47 | | | | | 47 |
| 48 | | | | | 48 |
| 49 | Total | | (34,200) | | 49 |
| ., | | | (5.,200) | | |

Summary A Facility Name & ID Number Heritage Manor East-Beardstown

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61 01/01/2004 Ending: # 0041632 Report Period Beginning: 12/31/2004

| | SUMMARY OF PAGES 5, 5A, 6, 6A | 1, 6B, 6C, 6D, 6 | 5E, 6F, 6G, 6H | I AND 61 | | | | | | | | | |
|-----|------------------------------------|------------------|----------------|----------|------|------|------|------|------|------------|------|------------|-------------------|
| | | | | | | | | | | | | | SUMMARY |
| | Operating Expenses | PAGES | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | TOTALS |
| | A. General Services | 5 & 5A | 6 | 6A | 6B | 6C | 6D | 6E | 6F | 6 G | 6H | 6 I | (to Sch V, col.7) |
| 1 | Dietary | 0 | 0 | 2,651 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,651 1 |
| 2 | Food Purchase | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 2 |
| 3 | Housekeeping | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 3 |
| 4 | Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 4 |
| 5 | Heat and Other Utilities | 0 | 0 | 812 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 812 5 |
| 6 | Maintenance | 0 | 0 | 9,509 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9,509 6 |
| 7 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 7 |
| 8 | TOTAL General Services | 0 | 0 | 12,972 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12,972 8 |
| | B. Health Care and Programs | | | | | | | | | | | | |
| 9 | Medical Director | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 9 |
| 10 | Nursing and Medical Records | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 10 |
| 10a | Therapy | 0 | 205,779 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 205,779 10 |
| 11 | Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 11 |
| 12 | Social Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 12 |
| 13 | Nurse Aide Training | 0 | 0 | 1,404 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,404 13 |
| 14 | - B | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 14 |
| 15 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 15 |
| 16 | TOTAL Health Care and Programs | 0 | 205,779 | 1,404 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 207,183 16 |
| | C. General Administration | | | | | | | | | | | | |
| 17 | Administrative | 0 | 0 | 47,735 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 47,735 17 |
| 18 | Directors Fees | 0 | 0 | 3,860 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,860 18 |
| 19 | Professional Services | (703) | (137,182) | 12,136 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (125,749) 19 |
| 20 | Fees, Subscriptions & Promotions | (9,304) | 0 | 2,609 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (6,695) 20 |
| 21 | Clerical & General Office Expenses | 0 | 0 | 96,090 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 96,090 21 |
| 22 | Employee Benefits & Payroll Taxes | 0 | 0 | 24,752 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24,752 22 |
| 23 | Inservice Training & Education | 0 | 0 | 392 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 392 23 |
| 24 | Travel and Seminar | (8,913) | 0 | 5,801 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (3,112) 24 |
| 25 | Other Admin. Staff Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 25 |
| 26 | Insurance-Prop.Liab.Malpractice | 0 | 0 | 1,449 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,449 26 |
| 27 | Other (specify):* | (23,800) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (23,800) 27 |
| 28 | TOTAL General Administration | (42,720) | (137,182) | 194,824 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14,922 28 |
| | TOTAL Operating Expense | | | | | | | | | | | | |
| 29 | (sum of lines 8,16 & 28) | (42,720) | 68,597 | 209,200 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 235,077 29 |

Summary B Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

| | | | | | | | | | | | | | SUMMARY | |
|----|------------------------------------|----------|--------|---------|--------|------|------|------|------|------------|------|------|----------------|-----|
| | Capital Expense | PAGES | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | PAGE | TOTALS | |
| | D. Ownership | 5 & 5A | 6 | 6A | 6B | 6C | 6D | 6E | 6F | 6 G | 6H | 6I | (to Sch V, col | .7) |
| 30 | Depreciation | 0 | 0 | 0 | 8,254 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8,254 | 30 |
| 31 | Amortization of Pre-Op. & Org. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| 32 | Interest | (23) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (23) | 32 |
| 33 | Real Estate Taxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| 34 | Rent-Facility & Grounds | 0 | 0 | 0 | 4,699 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,699 | 34 |
| 35 | Rent-Equipment & Vehicles | (393) | 0 | 0 | 1,850 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,457 | 35 |
| 36 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 36 |
| 37 | TOTAL Ownership | (416) | 0 | 0 | 14,803 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14,387 | 37 |
| | Ancillary Expense | | | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 38 |
| 39 | Ancillary Service Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 |
| 40 | Barber and Beauty Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40 |
| 41 | Coffee and Gift Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 41 |
| 42 | Provider Participation Fee | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 42 |
| 43 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 43 |
| 44 | TOTAL Special Cost Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 44 |
| | GRAND TOTAL COST | · | | · | | | | | | | | | | |
| 45 | (sum of lines 29, 37 & 44) | (43,136) | 68,597 | 209,200 | 14,803 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 249,464 | 45 |

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

| A. Lines below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule in necessary. | | | | | | | | | | |
|--|-------------|------|----------------------|-------|---|----------|---------------|-----------|------------------|--|
| 1 | | | 2 | | | 3 | | | | |
| OWNERS | | | RELATED NURSING HOME | ES | | OTHER RE | LATED BUSINES | S ENTITII | ES | |
| Name | Ownership % | Name | | City | | Name | City | | Type of Business | |
| | | | | - | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | - | | | | | |
| | | | | 10.00 | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

| | 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|-----|---------|------|---------------------------------|--------------|--------------------------------|-----------|----------------|----------------------|----|
| | | | _ | | | Percent | Operating Cost | Adjustments for | |
| Sch | edule V | Line | Item | Amount | Name of Related Organization | of | of Related | Related Organization | |
| | | | | | | Ownership | Organization | Costs (7 minus 4) | |
| 1 | V | | | \$ | | | \$ | \$ | 1 |
| 2 | V | 10a | Adjustment for Related Organiza | tion | GreenTree Therapy | 100.00% | | | 2 |
| 3 | V | | | | | | | | 3 |
| 4 | V | 19 | Adjustment for Related Organiza | tion 137,182 | Heritage Enterprises, Inc. | 100.00% | | (137,182) | 4 |
| 5 | V | | | | | | | | 5 |
| 6 | V | 10a | Adjustment for Related Organiza | tion 106,752 | GreenTree Pharmacy | 100.00% | 312,531 | 205,779 | 6 |
| 7 | V | | | | | | | | 7 |
| 8 | V | | | | | | | | 8 |
| 9 | V | | | | | | | | 9 |
| 10 | V | | | | | | | | 10 |
| 11 | V | | | | | | | _ | 11 |
| 12 | V | | | | | | | | 12 |
| 13 | V | | | | | | | | 13 |
| 14 | Total | | | \$ 243,934 | | | \$ 312,531 | \$ * 68,597 | 14 |

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

| | | LINOIS |
|--|--|--------|
| | | |

Page 6A Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

| VII. RELATED PARTIES (continu |
|-------------------------------|
|-------------------------------|

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

| | 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------|----------|------|------------------------------------|--------|--------------------------------|-----------|----------------|---|----|
| | _ | - | | | | Percent | Operating Cost | Adjustments for | |
| Saha | dule V | Line | Item | Amount | Name of Related Organization | of | of Related | Related Organization | |
| Sche | uuic v | Line | Item | Amount | Name of Related Organization | | | | |
| | | | =- | _ | | Ownership | Organization | Costs (7 minus 4) | |
| 15 | V | 1 | Dietary | \$ | Heritage Enterprises, Inc. | 100.00% | 7 | | 15 |
| 16 | <u>v</u> | 2 | Food Purchase | | | | 0 | | 16 |
| 17 | <u>v</u> | 3 | Housekeeping | | | | 0 | | 17 |
| 18 | V | 4 | Laundry | | | | 0 | | 18 |
| 19 | V | 5 | Heat & Other Utilities | | | | 812 | | 19 |
| 20 | V | 6 | Maintenance | | | | 9,509 | | 20 |
| 21 | V | 7 | Other | | | | 0 | | 21 |
| 22 | V | 9 | Medical Director | | | | 0 | | 22 |
| 23 | V | 10 | Nursing & Medical Records | | | | 0 | | 23 |
| 24 | V | 11 | Activities | | | | 0 | | 24 |
| 25 | V | 12 | Social Service | | | | 0 | | 25 |
| 26 | V | 13 | Nurse Aide Training | | | | 1,404 | | 26 |
| 27 | V | 14 | Program Transportation | | | | 0 | | 27 |
| 28 | V | 15 | Other | | | | 0 | | 28 |
| 29 | V | 17 | Administrative | | | | 47,735 | | 29 |
| 30 | V | 18 | Directors Fees | | | | 3,860 | -) | 30 |
| 31 | V | 19 | Professional Services | | | | 12,136 | 12,136 | 31 |
| 32 | V | 20 | Fees, Subscription, Promotions | | | | 2,609 | | 32 |
| 33 | V | 21 | Clerical & General Office Expenses | | | | 96,090 | 96,090 | 33 |
| 34 | V | 22 | Employee Benefits & Payroll Taxes | | | | 24,752 | 24,752 | 34 |
| 35 | V | 23 | Inservice Training & Education | | | | 392 | 392 | 35 |
| 36 | V | 24 | Travel and Seminar | | | | 5,801 | | 36 |
| 37 | V | 25 | Other Admin. Staff Transportation | | | | 0 | , in the second | 37 |
| 38 | V | 26 | Insurance-Prop.Liab.Malpract | | | | 1,449 | 1,449 | 38 |
| 39 | Total | | | \$ | | | s 209,200 | \$ * 209,200 | 39 |

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

| STATE OF ILLINOIS | | | |
|-------------------|--|--|--|
| | | | |
| | | | |

Page 6B # 0041632 Ending: 12/31/2004 Facility Name & ID Number Heritage Manor East-Beardstown Report Period Beginning: 01/01/2004

VII. RELATED PARTIES (continued)

| B. | Are any costs included in this report which are a result of transactions wit | h rela | ted organizat | ions? | This includes rent, |
|----|--|--------|---------------|-------|---------------------|
| | management fees, purchase of supplies, and so forth. | | YES | | NO |

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

| 1 | | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|---------|------|------|------------------------------|--------|--------------------------------|-----------|----------------|----------------------|----------|
| | | | | | | Percent | Operating Cost | Adjustments for | |
| Schedul | le V | Line | Item | Amount | Name of Related Organization | of | of Related | Related Organization | |
| | | | | | | Ownership | Organization | Costs (7 minus 4) | |
| 15 | V | 27 | Other | \$ | Heritage Enterprises, Inc. | Ownersmp | s 0 | | 15 |
| 16 | v | 30 | Depreciation | Ψ | Terrage Enterprises, inc. | | 8,254 | 8,254 | 16 |
| 17 | V | 31 | Amortization of Pre-Op & Org | | | | 0 | | 17 |
| 18 | V | 32 | Interest | | | | 0 | | 18 |
| 19 | V | 33 | Real Estate Taxes | | | | 0 | | 19 |
| 20 | V | 34 | Rent-Facility & Grounds | | | | 4,699 | 4,699 | 20 |
| 21 | V | 35 | Rent-Equipment & Vehicles | | | | 1,850 | 1,850 | 21 |
| 22 | V | 36 | Other | | | | 0 | | 22 |
| 23 | V | 38 | Medically Nec Transportation | | | | 0 | | 23 |
| 24 | V | 39 | Ancillary Service Centers | | | | 0 | | 24 |
| 25 | V | 40 | Barber and Beauty Shops | | | | 0 | | 25 |
| 26 | V | 41 | Coffee and Gift Shops | | | | 0 | | 26 |
| 27 | V | 42 | Other | | | | 0 | | 27 |
| 28 | V | | | | | | | | 28 |
| 29 | V | | | | | | | | 29 |
| 30 | V | | | | | | | | 30 |
| 31 | V | | | | | | | | 31 |
| 32 | V | | | | | | | | 32 |
| 33 | V | | | | | | | | 33 |
| 34 | V | | | | | | | | 34 |
| 35 | V | | | | | | | | 35 |
| 36 | V | | | | | | | | 36 37 |
| 37 | V | | | ļ | | | | | 37 |
| 38 | v | | | | | | | | |
| 39 Tot | tal | | | \$ | | | \$ 14,803 | \$ * 14,803 | 39 |

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7 Heritage Manor East-Beardstown 0041632 **Report Period Beginning:** 01/01/2004 12/31/2004 Facility Name & ID Number **Ending:**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

| | 1 | 2 | 3 | 4 | 5 | 6 | | 7 | | 8 | |
|----|-------------------|------------------------------|------------|-----------|----------------|--------------|--------------|-------------|-------------|-------------|----|
| | | | | | | Average Hou | rs Per Work | | | | |
| | | | | | Compensation | Week Deve | oted to this | Compensati | on Included | Schedule V. | |
| | | | | | Received | Facility and | % of Total | in Costs | for this | Line & | |
| | | | | Ownership | From Other | Work | Week | Reportin | g Period** | Column | |
| | Name | Title | Function | Interest | Nursing Homes* | Hours | Percent | Description | Amount | Reference | |
| 1 | Susie Jefferson | Director | Management | 15.86 | | 10 | | Salary/BOD | \$ 2,362 | Ln. 17/18 | 1 |
| 2 | Tom Jefferson | Secretary | Management | 16.21 | | 10 | | Salary/BOD | 10,136 | Ln. 17/18 | 2 |
| 3 | Craig Hart | | Management | 31.95 | | 10 | | Salary/BOD | 12,835 | Ln. 17/18 | 3 |
| 4 | Cheryl Lowney | Executive Vice Presid | Management | 0.49 | | 40 | 100.00 | Salary/BOD | 6,982 | Ln. 17/18 | 4 |
| 5 | Steve Wannemacher | President | Management | 0.42 | | 40 | 100.00 | Salary/BOD | 9,313 | Ln. 17/18 | 5 |
| 6 | Connie Hoselton | Sr Vice President | Management | 0.27 | | 40 | 100.00 | Salary | 4,629 | Ln. 17/18 | 6 |
| 7 | Craig Ater | Sr Vice President | Management | 0.34 | | 40 | 100.00 | Salary | 5,338 | Ln. 17/18 | 7 |
| 8 | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | İ | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | \$ 51,595 | | 13 |

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

| | Name of Related Organization | |
|--|------------------------------|-----|
| A. Are there any costs included in this report which were derived from allocations of central office | Street Address | |
| or parent organization costs? (See instructions.) YES NO | City / State / Zip Code | |
| - - | Phone Number | () |
| B. Show the allocation of costs below. If necessary, please attach worksheets. | Fax Number | |

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|----|------------|---|--------------------------|--------------------|-----------------------|-----------------------|------------------|----------|----------------------|----|
| | Schedule V | | Unit of Allocation | | Number of | Total Indirect | Amount of Salary | | | |
| | Line | | (i.e.,Days, Direct Cost, | | Subunits Being | Cost Being | Cost Contained | Facility | Allocation | |
| | Reference | Item | Square Feet) | Total Units | Allocated Among | Allocated | in Column 6 | Units | (col.8/col.4)x col.6 | |
| 1 | 1 | Dietary | Beds | 2,403 | 24 | \$ 89,729 | \$ 89,729 | 71 | \$ 2,651 | 1 |
| 2 | 2 | Food Purchase | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 2 |
| 3 | 3 | Housekeeping | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 3 |
| 4 | 4 | | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 4 |
| 5 | 5 | Heat & Other Utilities | Beds | 2,403 | 24 | 27,471 | 0 | 71 | 812 | 5 |
| 6 | 6 | Maintenance | Beds | 2,403 | 24 | 321,832 | 76,617 | 71 | 9,509 | 6 |
| 7 | | | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 7 |
| 8 | 9 | Medical Director | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 8 |
| 9 | 10 | Nursing & Medical Records | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 9 |
| 10 | 11 | Activities | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 10 |
| 11 | 12 | Social Service | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 11 |
| 12 | 13 | Nurse Aide Training | Beds | 2,403 | 24 | 47,533 | 39,159 | 71 | 1,404 | 12 |
| 13 | 14 | Program Transportation | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 13 |
| 14 | 15 | Other | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 14 |
| 15 | 17 | Administrative | Beds | 2,403 | 24 | 1,615,588 | 1,615,588 | 71 | 47,735 | 15 |
| 16 | 18 | Directors Fees | Beds | 2,403 | 24 | 130,630 | 0 | 71 | 3,860 | 16 |
| 17 | 19 | Professional Services | Beds | 2,403 | 24 | 410,747 | 0 | 71 | 12,136 | 17 |
| 18 | 20 | Fees, Subscription, Promotions | Beds | 2,403 | 24 | 88,297 | 0 | 71 | 2,609 | 18 |
| 19 | 21 | Clerical & General Office Expense | Beds | 2,403 | 24 | 3,252,161 | 2,929,944 | 71 | 96,090 | 19 |
| 20 | 22 | Employee Benefits & Payroll Taxe | Beds | 2,403 | 24 | 837,746 | 0 | 71 | 24,752 | 20 |
| 21 | | 8 | Beds | 2,403 | 24 | 13,283 | 0 | 71 | 392 | 21 |
| 22 | 24 | Travel and Seminar | Beds | 2,403 | 24 | 196,325 | 0 | 71 | 5,801 | 22 |
| 23 | 25 | Other Admin. Staff Transportatio | Beds | 2,403 | 24 | 0 | 0 | 71 | 0 | 23 |
| 24 | 26 | Insurance-Prop.Liab.Malpract | Beds | 2,403 | 24 | 49,040 | 0 | 71 | 1,449 | 24 |
| 25 | TOTALS | | | | | \$ 7,080,382 | \$ 4,751,037 | | \$ 209,200 | 25 |

STATE OF ILLINOIS Page 8A

| Facility Name & ID Number | Heritage Manor East-Beardstown | # | 0041632 | Report Period Beginning: | 01/01/2004 | Ending: | 2/31/2004 |
|---------------------------|--------------------------------|---|---------|--------------------------|------------|---------|-----------|
| VIII. ALLOCATION OF INDIR | ECT COSTS | | | | | | |

| III. ALLUCATION OF INDIRECT COSTS | | |
|--|------------------------------|-----|
| | Name of Related Organization | |
| A. Are there any costs included in this report which were derived from allocations of central office | Street Address | |
| or parent organization costs? (See instructions.) YES NO | City / State / Zip Code | |
| _ | Phone Number | () |
| B. Show the allocation of costs below. If necessary, please attach worksheets. | Fax Number | |

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | \Box |
|----|------------|----------------------------------|--------------------------|-------------|-----------------|----------------|------------------|----------|----------------------|--------|
| | Schedule V | | Unit of Allocation | | Number of | Total Indirect | Amount of Salary | | | |
| | Line | | (i.e.,Days, Direct Cost, | | Subunits Being | Cost Being | Cost Contained | Facility | Allocation | |
| | Reference | Item | Square Feet) | Total Units | Allocated Among | Allocated | in Column 6 | Units | (col.8/col.4)x col.6 | |
| 1 | 27 | Other | Beds | 2,403 | 24 | \$ | \$ | 71 | | 1 |
| 2 | 30 | Depreciation | Beds | 2,403 | 24 | 279,369 | | 71 | 8,254 | 2 |
| 3 | 31 | Amortization of Pre-Op & Org | Beds | 2,403 | 24 | Í | | 71 | | 3 |
| 4 | 32 | Interest | Beds | 2,403 | 24 | | | 71 | | 4 |
| 5 | 33 | Real Estate Taxes | Beds | 2,403 | 24 | | | 71 | | 5 |
| 6 | | Rent-Facility & Grounds | Beds | 2,403 | 24 | 159,040 | | 71 | 4,699 | 6 |
| 7 | 35 | Rent-Equipment & Vehicles | Beds | 2,403 | 24 | 62,608 | | 71 | 1,850 | 7 |
| 8 | 36 | Other | Beds | 2,403 | 24 | | | 71 | | 8 |
| 9 | 38 | Medically Nec Transportation | Beds | 2,403 | 24 | | | 71 | | 9 |
| 10 | 39 | Ancillary Service Centers | Beds | 2,403 | 24 | | | 71 | | 10 |
| 11 | 40 | Barber and Beauty Shops | Beds | 2,403 | 24 | | | 71 | | 11 |
| 12 | 41 | Coffee and Gift Shops | Beds | 2,403 | 24 | | | 71 | | 12 |
| 13 | 42 | Other | Beds | 2,403 | 24 | | | 71 | | 13 |
| 14 | | | | | | | | 71 | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ 501,017 | \$ | | \$ 14,803 | 25 |

Heritage Manor East-Beardstown

0041632

Report Period Beginning:

01/01/2004 Ending:

Page 9 12/31/2004

| IX. INTEREST EXPENSE AND REAL ESTATE T | AX EXPENSI |
|--|------------|

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

| | 1 | 2 | • | 3 | 4 | 5 | • | 6 | 7 | 8 | 9 | 10 | |
|----|---|---------------|------------|-----------------|--------------------------------|-----------------|----|----------------|-----------------------|------------------|--------------------------------|--|------|
| | Name of Lender | Relate YES | ed** NO | Purpose of Loan | Monthly Payment Required | Date of Note | Or | Amou iginal | nt of Note Balance | Maturity Date | Interest Rate (4 Digits) | Reporting Period Interest Expense | |
| | A. Directly Facility Related | | | | | • | | | | | | • | |
| | Long-Term | | | | | | | | | | | | |
| 1 | Bank One | | XX | Mortgage | 4640 plus Int | 01/15/99 | \$ | | \$ 1,057,339 | 01/15/06 | variable | \$ 48,906 | 1 |
| 2 | Bank One | | XX | Mortgage | | | | | | | | | 2 |
| 3 | | | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | | | 5 |
| | Working Capital | | | | | · | | | | | | | |
| 6 | Central Office Allocation | | XX | Working Capital | | | | | | | | 7,857 | 6 |
| 7 | Central Office Allocation | | XX | Working Capital | | | | | | | | | 7 |
| 8 | | | | | | | | | | | | | 8 |
| 9 | TOTAL Facility Related B. Non-Facility Related* | | | | | | \$ | | \$ 1,057,339 | | | \$ 56,763 | 9 |
| 10 | Interest Income | | | | T | | Ī | | | | | (23) | 10 |
| 11 | Interest income | | | | | | | | | | | (23) | 11 |
| 12 | | | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | | | 13 |
| 13 | | | | | | | | | | | | | 15 |
| 14 | TOTAL Non-Facility Related | | | | | | \$ | | \$ | | | \$ (23) |) 14 |
| 15 | TOTALS (line 9+line14) | | | | | | \$ | | \$ 1,057,339 | | | \$ 56,740 | 15 |

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line #

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0041632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

Facility Name & ID Number Heritage Manor East-Beardstown

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

| B. Real Estate Taxes | | | | | | |
|---|---|-----------------------------|-----------------------------|--------------|--------|----|
| | Important, please see the next worksheet | t, "RE_Tax". The real | estate tax statement and | | | |
| 1. Real Estate Tax accrual used on 2003 report. | bill must accompany the cost report. | | | s | 23,654 | 1 |
| 2. Real Estate Taxes paid during the year: (Indicate | the tax year to which this payment applies. If payment cov | vers more than one year, de | tail below.) | s | 23,096 | 2 |
| 3. Under or (over) accrual (line 2 minus line 1). | | | | s | (558) | 3 |
| 4. Real Estate Tax accrual used for 2004 report. (I | Detail and explain your calculation of this accrual on the line | es below.) | | \$ | 24,255 | 4 |
| ** | ch has NOT been included in professional fees or other gen | | | \$ | | 5 |
| 6. Subtract a refund of real estate taxes. You must classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For | , 11 | eal estate tax appeal | board's decision.) | \$ | | 6 |
| 7. Real Estate Tax expense reported on Schedule V | 7, line 33. This should be a combination of lines 3 thru 6. | | | s | 23,697 | 7 |
| Real Estate Tax History: | | | | | | |
| | 1999 19,859 8 | | FOR OHF USE ONLY | | | |
| | 2000 20,563 9 2001 22,281 10 | 13 | FROM R. E. TAX STATEMENT FO | OR 2003 \$ | | 13 |
| | 2002 22,916 11 2003 23,197 12 | 14 | PLUS APPEAL COST FROM LINE | 5 \$ | | 14 |
| | | 15 | LESS REFUND FROM LINE 6 | \$ | | 15 |
| | | 16 | AMOUNT TO USE FOR RATE CAL | LCULATION \$ | | 16 |

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

| FAC | ILITY NAME | Heritage Manor E | ast-Beardstown | | COUNTY | Cass | |
|-----------|--|--|--|---------------------------------|--------------------------------------|-----------------|------------------------------------|
| FAC | ILITY IDPH LICE | ENSE NUMBER | 0041632 | | | | |
| CON | TACT PERSON I | REGARDING THIS | REPORT | | | | |
| TEL | EPHONE (|) | FAX | #: () | | | |
| A. | | al Estate Tax Cost | | | | | |
| | cost that applies t home property w | to the operation of the hich is vacant, rente | estate tax assessed for 2003 on the nursing home in Column D. dt to other organizations, or use the cost for any period other than | Real estate ta d for purpose | ax applicable to s other than lon | any portion of | the nursing |
| | (A |) | (B) | | (C) | | (D) |
| | Tax Index | <u>Number</u> | Property Description | | Total Tax | | Tax pplicable to ursing Home |
| 1. | 03-264-007-00 | | | \$ | 23,096.00 | \$ | 23,096.00 |
| 2. | | | | \$ | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. 9. | | | | _ \$ | | - *- | |
| 9. 10. | | | | _ • | | | |
| 10. | | | | | | | |
| | | | TOTA | LS \$ | 23,096.00 | s | 23,096.00 |
| B. | Real Estate Tax | Cost Allocations | | | | | |
| | Does any portion used for nursing l | | to more than one nursing hom YES | e, vacant prop NO | perty, or proper | ty which is not | directly |
| | | | hedule which shows the calcula ast be allocated to the nursing he | | | | ie. |
| C | Tay Pills | | | | | | |

 $Attach\ a\ copy\ of\ the\ original\ 2003\ tax\ bills\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2003$

tax bill which is normally paid during 2004.

Page 10A

| S | ГАТ | EΩ | $\mathbf{F}\mathbf{\Pi}$ | INOI | S |
|---|-----|----|--------------------------|------|---|

40,000

Page 11

Facility Name & ID Number Heritage Manor East-Beardstown 0041632 Report Period Beginning: 01/01/2004 Ending: 12/31/2004 X. BUILDING AND GENERAL INFORMATION: 9,428 **B.** General Construction Type: brick/wood **Number of Stories** Square Feet: Exterior Frame wood (c) Rent from Completely Unrelated Does the Operating Entity? xx (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) xx (a) Own the Equipment (c) Rent equipment from Completely Does the Operating Entity? (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? XX If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3 Square Feet Year Acquired A. Land. Use Cost land 40,000

3 TOTALS

Facility Name & ID Number Heritage Manor East-Beardstown # 004 XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 | ng Depreciation-Including Fixed Equ | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | \neg |
|----|---------------|-------------------------------------|----------|-------------|--------------|----------------|-----------|----------------|--------------|--------------|--------|
| | • | FOR OHF USE ONLY | Year | Year | 7 | Current Book | Life | Straight Line | | Accumulated | |
| | Beds* | TOR OIL USE OILE | Acquired | Constructed | Cost | Depreciation | in Years | Depreciation | Adjustments | Depreciation | |
| 4 | 71 | | Acquirea | Constructed | \$ 1,744,500 | © Depreciation | III Tears | © Depreciation | Yajustinents | S | 4 |
| 5 | - '- | | | | 3 1,744,500 | Ψ | | J | Ψ | g. | 5 |
| 6 | | | | | | | | | | | 6 |
| | | | | | | | | | | | |
| 7 | | | | | | | | | | | 7 |
| 8 | | 177 | | | | | | | | | 8 |
| | | vement Type** | | 100- | 0.031 | | | | | | |
| | Shower Remo | | | 1997 | 9,921 | | | | | | 9 |
| - | Heat/Cool Un | its | | 1997 | 2,138 | | | | | | 10 |
| | Roof | | | 1997 | 101,691 | | | | | | 11 |
| | Interior Reha | D | | 1997 | 87,411 | | | | | | 12 |
| 13 | | | | 1007 | 2.255 | | | | | | 13 |
| | Five Ton Hea | | | 1996 | 3,257 | | | | | | 14 |
| | Heritage Man | | | 1996 | 2,145 | | | | | | 15 |
| | Remodel Phys | sical Therapy Room | | 1996 | 18,303 | | | | | | 16 |
| 17 | | | | | | | | | | | 17 |
| | Smoke Detect | | | 1998 | 5,431 | | | | | | 18 |
| | Back Flow Pr | | | 1998 | 3,155 | | | | | | 19 |
| | Interior Reha | b | | 1998 | 144,749 | | | | | | 20 |
| 21 | | | | ****** | 2.00 | | | | | | 21 |
| | Water Heater | | | 1999 | 3,991 | | | | | | 22 |
| | Alzheimer Un | | | 1999 | 51,576 | | | | | | 23 |
| | Alzheimer Un | | | 1999 | 14,502 | | | | | | 24 |
| | | itProfessional Fees | | 1999 | 21,605 | | | | | | 25 |
| | Interior Reha | D | | 1999 | 30,944 | | | | | | 26 |
| 27 | | | | 3000 | 25.445 | | | | | | 27 |
| | Alzheimer Un | | | 2000 | 27,447 | | | | | | 28 |
| | Alzheimer Un | | | 2000 | 5,812 | | | | | | 29 |
| | | itProfessional Fees | | 2000 | 1,310 | | | | | | 30 |
| | Fire Alarm Pa | | | 2001 | 2,026 | | | | | | 31 |
| | Electric Door | | | 2001 | 2,378 | | | | | | 32 |
| 33 | | | | | | | | 0.255 | 0.25- | | 33 |
| | C/O Allocatio | | | | | 5.5.5.3 | | 8,255 | 8,255 | | 34 |
| | Book Depreci | ation | | | | 75,523 | | 75,523 | | 597,223 | 35 |
| 36 | | | | | | | | | | | 36 |

See Page 12A, Line 70 for total

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS # 0041632 Report Period Beginning: Page 12A 12/31/2004

01/01/2004 Ending:

Facility Name & ID Number Heritage Manor East-Beardstown # 004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | B. Building Depreciation-Including Fixed Equipment. (See instr | 3 | an numbers to near | 5 | 6 | 7 | 8 | 9 | |
|-----|--|--------------|--------------------|--------------|--------------|---------------|-------------|--------------|-----|
| | 1 | Year | • | Current Book | Life | Straight Line | · · | Accumulated | |
| | Improvement Type** | Constructed | Cost | Depreciation | in Years | Depreciation | Adjustments | Depreciation | |
| 37 | Improvement Type | Constitueteu | S | S | III Tears | S | S | S | 37 |
| 38 | Heat/Cool Unit | 2002 | 742 | * | | * | * | - | 38 |
| 39 | Heat/Cool Unit | 2002 | 1,190 | | | | | | 39 |
| 40 | | | -,, | | | | | | 40 |
| 41 | Heat Cool Unit | 2003 | 104 | | | | | | 41 |
| 42 | Service Sink | 2003 | 691 | | İ | | | | 42 |
| 43 | Security System | 2003 | 2,160 | | | | | | 43 |
| 44 | Compressor | 2003 | 2,244 | | | | | | 44 |
| 45 | Excerciser Clock | 2003 | 1,243 | | | | | | 45 |
| 46 | A/C Unit | 2003 | 568 | | | | | | 46 |
| 47 | | | | | | | | | 47 |
| 48 | Carpet | 2004 | 3,280 | | | | | | 48 |
| 49 | Heat/Cool Unit | | 2,877 | | | | | | 49 |
| 50 | Condensing Unit | | 1,861 | | | | | | 50 |
| 51 | Electronic Door | | 624 | | | | | | 51 |
| 52 | | | | | | | | | 52 |
| 53 | | | | | | | | | 53 |
| 54 | | | | | | | | | 54 |
| 55 | | | | | | | | | 55 |
| 56 | | | | | | | | | 56 |
| 57 | | | | | | | | | 57 |
| 58 | | | | | | | | | 58 |
| 59 | | | | | | | | | 59 |
| 60 | | | | | | | | | 60 |
| 62 | | | | | - | | | | 62 |
| 63 | | | | | - | | | | 63 |
| 64 | | | | | | | | | 64 |
| 65 | | | | | | | | | 65 |
| 66 | | | | | + | | | | 66 |
| 67 | | | | | | | | | 67 |
| 68 | | | | <u> </u> | | | | | 68 |
| 69 | | | | 1 | | | | | 69 |
| | TOTAL (lines 4 thru 69) | | \$ 2,301,876 | \$ 75,523 | | s 83,778 | \$ 8,255 | \$ 597,223 | 70 |
| 7.0 | 101112 (mts 1 m u v) | | 2,501,070 | 75,520 | | 30,770 | ÷ 0,233 | 377,220 | 7.0 |

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

| STA | | | |
|-----|--|--|--|
| | | | |
| | | | |

Page 13 Facility Name & ID Number 0041632 **Report Period Beginning:** 01/01/2004 Ending: 12/31/2004 Heritage Manor East-Beardstown

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

| | Category of | 1 | | Current Book | Straight Line | 4 | Component | Accumulated | |
|----|--------------------------|----------|----|----------------|----------------|-------------|-----------|----------------|----|
| | Equipment | Cost | | Depreciation 2 | Depreciation 3 | Adjustments | Life 5 | Depreciation 6 | |
| 71 | Purchased in Prior Years | \$ 234,6 | 92 | \$ 12,786 | \$ 12,786 | \$ | | \$ 218,985 | 71 |
| 72 | Current Year Purchases | 17,3 | 35 | | | | | | 72 |
| 73 | Fully Depreciated Assets | | | | | | | | 73 |
| 74 | | | | | | | | | 74 |
| 75 | TOTALS | \$ 252,0 | 77 | \$ 12,786 | \$ 12,786 | \$ | | \$ 218,985 | 75 |

D. Vehicle Depreciation (See instructions.)*

| | 1 | Model, Make | Year | 4 | Current Book | Straight Line | 7 | Life in | Accumulated | |
|----|--------|-------------|------------|------|----------------|----------------|-------------|---------|----------------|----|
| | Use | and Year 2 | Acquired 3 | Cost | Depreciation 5 | Depreciation 6 | Adjustments | Years 8 | Depreciation 9 | |
| 76 | | | | \$ | \$ | \$ | \$ | | \$ | 76 |
| 77 | | | | | | | | | | 77 |
| 78 | | | | | | | | | | 78 |
| 79 | | | | | | | | | | 79 |
| 80 | TOTALS | | | \$ | \$ | \$ | \$ | | \$ | 80 |

E. Summary of Care-Related Assets

| | L. Sullillary of Care-Kelateu Assets | 1 | 2 | | |
|----|--------------------------------------|--|-----------------|----|----|
| | | Reference | Amount | | j |
| 81 | Total Historical Cost | (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable) | \$ 2,593,953 | 81 |] |
| 82 | Current Book Depreciation | (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) | \$ 88,309 | 82 |] |
| 83 | Straight Line Depreciation | (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) | \$ 96,564 | 83 | ** |
| 84 | Adjustments | (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable) | \$ 8,255 | 84 | 1 |
| 85 | Accumulated Depreciation | (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L if applicable) | \$ 816,208 | 85 | 1 |

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

| | 1 | 2 | Current Book | Accumulated | İ |
|----|-----------------------------|------|----------------|----------------|----|
| | Description & Year Acquired | Cost | Depreciation 3 | Depreciation 4 | |
| 86 | | \$ | \$ | \$ | 86 |
| 87 | | | | | 87 |
| 88 | | | | | 88 |
| 89 | | | | | 89 |
| 90 | | | | | 90 |
| 91 | TOTALS | \$ | \$ | \$ | 91 |

G. Construction-in-Progress

| | Description | Cost | |
|----|-------------|------|----|
| 92 | | \$ | 92 |
| 93 | | | 93 |
| 94 | | | 94 |
| 95 | | \$ | 95 |

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

| Faci | lity Name & l | ID Number | Heritage Ma | nor East-Bo | eardstown | | # 0041632 | K | keport Period | Beginning: 01/01/2004 Ending: 12/31/20 |
|----------|------------------------|---------------------------------|--------------------|-------------|-------------|----------------------------|-----------------------|------------------|---------------|--|
| XII. | 1. Name of 2. Does the | and Fixed Equi Party Holding | | ĺ | n to rental | amount shown below on l | ine 7, column 4? |]NO | | |
| | | 1 | 2 | | 3 | 4 | 5 | 6 | | |
| | | Year | Numb | | Original | Rental | Total Years | Total Yea | | |
| | 0 : : 1 | Constructed | d of Bec | ls L | ease Date | Amount | of Lease | Renewal Op | tion* | 10 Fee (* 1 , e |
| , | Original Building: | | | | | • | | | , | 10. Effective dates of current rental agreement: |
| 3 | Additions | | | | | 3 | | | 3 4 | Beginning Ending |
| 5 | riduitions | | | | | | | | 5 | Enumg |
| 6 | | | | | | | | | 6 | 11. Rent to be paid in future years under the curren |
| 7 | TOTAL | | | | | \$ | | | 7 | rental agreement: |
| | by the le | ength of the leas | YES | <u>·</u> | NO | Terms: See instructions.) | * | | | 12. /2005 \$ 13. /2006 \$ 14. /2007 \$ |
| | | | rental included in | | | see mstructions.) | YES | NO | | |
| | | | vable equipment: | | 290 | Description: | pager, computer equip | | | |
| | | | | | | | (Attach a schedu | le detailing the | breakdown | of movable equipment) |
| | C. Vehicle R | Rental (See instr | | | | | | | | |
| | 1 | | 2 Model Yea | | | 3 Monthly Lease | Rental Expense | . | | |
| | Use | | and Make | | | Payment Payment | for this Period | | | * If there is an option to buy the building, |
| 17 | | | | \$ | | | \$ | 17 | | please provide complete details on attached |
| 18 | | | | | | | | 18 | | schedule. |
| 19 20 | | | | | | | | 19 20 | | ** This amount plus any amortization of lease |
| | TOTAL | | | e | | | • | 21 | | expense must agree with page 4, line 34. |
| 21 | IUIAL | | | 3 | | | Ф | 41 | | expense must agree with page 4, line 34. |

| | | STATE OF ILLINOIS | | | | Page 15 |
|---------------------------|--------------------------------|-------------------|---------|--------------------------|--------------------|-----------|
| Facility Name & ID Number | Heritage Manor East-Beardstown | # | 0041632 | Report Period Beginning: | 01/01/2004 Ending: | 12/31/200 |

| XIII. EXPENSES RELATING TO NURSE AIDE TRAINING | F PROGRAMS (See i | nstructions.) | | | _ | |
|---|------------------------|-------------------|--------------------|---------------|---------------|--|
| A. TYPE OF TRAINING PROGRAM (If aides are train | ed in another facility | nrogram, attach a | schedule listing t | he facility r | name address | and cost per aide trained in that facility) |
| 1. HAVE YOU TRAINED AIDES DURING THIS REPORT | | cLASSROOM | | | iame, address | 3. CLINICAL PORTION: |
| PERIOD? | NO | IN-HOUSE PR | OGRAM | | | IN-HOUSE PROGRAM |
| | IN OTHER FACILITY | | CILITY | | | IN OTHER FACILITY |
| If "yes", please complete the remainder of this schedule. If "no", provide an | | COMMUNITY | COLLEGE | | | HOURS PER AIDE |
| explanation as to why this training was not necessary. | | HOURS PER A | AIDE | | | |
| B. EXPENSES | ALLOCAT 1 | ION OF COSTS | (d) 3 | | 4 | C. CONTRACTUAL INCOME In the box below record the amount of income your facility received training aides from other facilities. |
| | F | acility | | | - | lacinty received training aides from other facilities. |
| | Drop-outs | Completed | Contract | | Total | \$ |
| 1 Community College Tuition | \$ | \$ | \$ | \$ | | |
| 2 Books and Supplies | | 383 | | | 383 | D. NUMBER OF AIDES TRAINED |
| 3 Classroom Wages (a) | | 941 | | | 941 | |
| 4 Clinical Wages (b) | | | | | | COMPLETED |
| 5 In-House Trainer Wages (c) | | | | | | 1. From this facility |
| 6 Transportation | | | | | | 2. From other facilities (f) |
| 7 Contractual Payments | | | | | | DROP-OUTS |
| 8 Nurse Aide Competency Tests | | | | | • | 1. From this facility |
| 9 TOTALS | \$ | \$ 1,324 | \$ | \$ | 1,324 | 2. From other facilities (f) |
| 10 SUM OF line 9, col. 1 and 2 (e) | \$ 1,324 | | | | • | TOTAL TRAINED |

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 12/31/2004

01/01/2004 Ending:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

| | v. Si Eenil SERvices (Bitti Cost) (i | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
|----|--------------------------------------|---------------|-----------|------|----------|-----------------|-------------|----------------|------------------|----|
| | | Schedule V | Staf | Î | Outsio | le Practitioner | Supplies | | | |
| | Service | Line & Column | Units of | Cost | (other t | han consultant) | (Actual or) | Total Units | Total Cost | |
| | | Reference | Service | | Units | Cost | Allocated) | (Column 2 + 4) | (Col. 3 + 5 + 6) | |
| 1 | Licensed Occupational Therapist | | hrs | \$ | | \$ 18,985 | \$ | ! | 18,985 | 1 |
| | Licensed Speech and Language | | | | | | | | | |
| 2 | Development Therapist | | hrs | | | 27,869 | | | 27,869 | 2 |
| 3 | Licensed Recreational Therapist | | hrs | | | | | | | 3 |
| 4 | Licensed Physical Therapist | | hrs | | | 22,804 | 79 | | 22,883 | 4 |
| 5 | Physician Care | | visits | | | | | | | 5 |
| 6 | Dental Care | | visits | | | | | | | 6 |
| 7 | Work Related Program | | hrs | | | | | | | 7 |
| 8 | Habilitation | | hrs | | | | | | | 8 |
| | | | # of | | | | | | | |
| 9 | Pharmacy | | prescrpts | | | | 312,614 | | 312,614 | 9 |
| | Psychological Services | | | | | | | | | |
| | (Evaluation and Diagnosis/ | | | | | | | | | |
| 10 | Behavior Modification) | | hrs | | | | | | | 10 |
| 11 | Academic Education | | hrs | | | | | | | 11 |
| 12 | Exceptional Care Program | | | | | | | | | 12 |
| | | | | | | | | | | |
| 13 | Other (specify): | | | | | 9,246 | | | 9,246 | 13 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| 14 | TOTAL | | | \$ | | \$ 78,904 | \$ 312,693 | | 391,597 | 14 |

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor East-Beardstown XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached.

As of 12/31/2004 (last day of reporting year)

| | | 1 | | 2 After | |
|----|---|----|-------------|----------------|----|
| | | C | perating | Consolidation* | |
| | A. Current Assets | | | | |
| 1 | Cash on Hand and in Banks | \$ | 10,297 | \$ | 1 |
| 2 | Cash-Patient Deposits | | 12,539 | | 2 |
| | Accounts & Short-Term Notes Receivable- | | | | |
| 3 | Patients (less allowance) | | 303,651 | | 3 |
| 4 | Supply Inventory (priced at) | | | | 4 |
| 5 | Short-Term Investments | | | | 5 |
| 6 | Prepaid Insurance | | 14,677 | | 6 |
| 7 | Other Prepaid Expenses | | | | 7 |
| 8 | Accounts Receivable (owners or related parties) | | (1,581,821) | | 8 |
| 9 | Other(specify): | | | | 9 |
| | TOTAL Current Assets | | | | |
| 10 | (sum of lines 1 thru 9) | \$ | (1,240,657) | \$ | 10 |
| | B. Long-Term Assets | | | | |
| 11 | Long-Term Notes Receivable | | | | 11 |
| 12 | Long-Term Investments | | | | 12 |
| 13 | Land | | 40,000 | | 13 |
| 14 | Buildings, at Historical Cost | | 2,301,878 | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | | | | 15 |
| 16 | Equipment, at Historical Cost | | 252,077 | | 16 |
| 17 | Accumulated Depreciation (book methods) | | (816,207) | | 17 |
| 18 | Deferred Charges | | | | 18 |
| 19 | Organization & Pre-Operating Costs | | | | 19 |
| | Accumulated Amortization - | | | | |
| 20 | Organization & Pre-Operating Costs | | | | 20 |
| 21 | Restricted Funds | | | | 21 |
| 22 | Other Long-Term Assets (specify): | | | | 22 |
| 23 | Other(specify): | | | | 23 |
| | TOTAL Long-Term Assets | | | | |
| 24 | (sum of lines 11 thru 23) | \$ | 1,777,748 | \$ | 24 |
| | · | | | | |
| | TOTAL ASSETS | | | | |
| 25 | (sum of lines 10 and 24) | \$ | 537,091 | \$ | 25 |

| | | 1 0 | perating | 2 After Consolidati | on* |
|-------|---------------------------------------|-----|------------|------------------------|------|
| | C. Current Liabilities | | | | |
| 26 | Accounts Payable | \$ | 42,582 | \$ | 26 |
| 27 | Officer's Accounts Payable | | | | 27 |
| 28 | Accounts Payable-Patient Deposits | | 12,539 | | 28 |
| 29 | Short-Term Notes Payable | | | | 29 |
| 30 | Accrued Salaries Payable | | 95,377 | | 30 |
| | Accrued Taxes Payable | | | | |
| 31 | (excluding real estate taxes) | | 2,476 | | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | | 24,255 | | 32 |
| 33 | Accrued Interest Payable | | 308 | | 33 |
| 34 | Deferred Compensation | | | | 34 |
| 35 | Federal and State Income Taxes | | | | 35 |
| | Other Current Liabilities(specify): | | | | |
| 36 | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | | 36 |
| 37 | | | | | 37 |
| | TOTAL Current Liabilities | | | | |
| 38 | (sum of lines 26 thru 37) | \$ | 177,537 | \$ | 38 |
| | D. Long-Term Liabilities | | | | |
| 39 | Long-Term Notes Payable | | | | 39 |
| 40 | Mortgage Payable | | 1,057,339 | | 40 |
| 41 | Bonds Payable | | | | 41 |
| 42 | Deferred Compensation | | | | 42 |
| | Other Long-Term Liabilities(specify): | | | | |
| 43 | | | | | 43 |
| 44 | | | | | 44 |
| | TOTAL Long-Term Liabilities | | | | |
| 45 | (sum of lines 39 thru 44) | \$ | 1,057,339 | \$ | 45 |
| | TOTAL LIABILITIES | | , , | | |
| 46 | (sum of lines 38 and 45) | \$ | 1,234,876 | \$ | 46 |
| | (sum of fines co and 15) | Ψ | 1,20 1,070 | • | - 10 |
| 47 | TOTAL EQUITY(page 18, line 24) | \$ | (697,785) | \$ | 47 |
| • • • | TOTAL LIABILITIES AND EQUITY | | (0)1,100) | | ** |
| 48 | (sum of lines 46 and 47) | \$ | 537,091 | \$ | 48 |
| 40 | (sum of fines 40 and 47) | Φ | 337,091 | Ф | |

^{*(}See instructions.)

Facility Name & ID Number Heritage Manor East-Beardstown
XVI. STATEMENT OF CHANGES IN EQUITY

1 Total

| | | | I otal | | |
|----|--|----|-----------|----|---|
| 1 | Balance at Beginning of Year, as Previously Reported | \$ | (688,907) | 1 | 1 |
| 2 | Restatements (describe): | | | 2 | 1 |
| 3 | | | | 3 |] |
| 4 | | | | 4 |] |
| 5 | | | | 5 | |
| 6 | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ | (688,907) | 6 | |
| | A. Additions (deductions): | | | | |
| 7 | NET Income (Loss) (from page 19, line 43) | | (8,878) | 7 | |
| 8 | Aquisitions of Pooled Companies | | | 8 | |
| 9 | Proceeds from Sale of Stock | | | 9 | |
| 10 | Stock Options Exercised | | | 10 | |
| 11 | Contributions and Grants | | | 11 | |
| 12 | Expenditures for Specific Purposes | | | 12 | |
| 13 | Dividends Paid or Other Distributions to Owners | (|) | 13 | |
| 14 | Donated Property, Plant, and Equipment | | | 14 | |
| 15 | Other (describe) | | | 15 | |
| 16 | Other (describe) | | | 16 | |
| 17 | TOTAL Additions (deductions) (sum of lines 7-16) | \$ | (8,878) | 17 | |
| | B. Transfers (Itemize): | | | | |
| 18 | | | | 18 | |
| 19 | | | | 19 | |
| 20 | | | | 20 | |
| 21 | | | | 21 | |
| 22 | | | | 22 | |
| 23 | TOTAL Transfers (sum of lines 18-22) | \$ | | 23 | |
| 24 | BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) | \$ | (697,785) | 24 | , |
| | | | | | |

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

| 1 | | |
|---|--|--|
| | | |
| | | |

| | Revenue | Amount | |
|-----|--|-----------------|-----|
| | A. Inpatient Care | | |
| 1 | Gross Revenue All Levels of Care | \$ 2,189,663 | 1 |
| 2 | Discounts and Allowances for all Levels | (364,492) | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 1,825,171 | 3 |
| | B. Ancillary Revenue | | |
| 4 | Day Care | | 4 |
| 5 | Other Care for Outpatients | | 5 |
| 6 | Therapy | 163,059 | 6 |
| 7 | Oxygen | | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ 163,059 | 8 |
| | C. Other Operating Revenue | | |
| 9 | Payments for Education | | 9 |
| 10 | Other Government Grants | | 10 |
| 11 | Nurses Aide Training Reimbursements | | 11 |
| 12 | Gift and Coffee Shop | 673 | 12 |
| 13 | Barber and Beauty Care | 272 | 13 |
| 14 | Non-Patient Meals | | 14 |
| 15 | Telephone, Television and Radio | | 15 |
| 16 | Rental of Facility Space | | 16 |
| 17 | Sale of Drugs | 184,582 | 17 |
| 18 | Sale of Supplies to Non-Patients | | 18 |
| 19 | Laboratory | | 19 |
| 20 | Radiology and X-Ray | | 20 |
| 21 | Other Medical Services | 4,953 | 21 |
| 22 | Laundry | | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ 190,480 | 23 |
| | D. Non-Operating Revenue | | |
| 24 | Contributions | | 24 |
| 25 | Interest and Other Investment Income*** | 23 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 23 | 26 |
| | E. Other Revenue (specify):**** | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | | | 28 |
| 28a | | | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 2,178,733 | 30 |

| | | 2 | |
|----|---|-----------------|----|
| | Expenses | Amount | |
| | A. Operating Expenses | | |
| 31 | General Services | 424,781 | 31 |
| 32 | Health Care | 1,001,078 | 32 |
| 33 | General Administration | 589,918 | 33 |
| | B. Capital Expense | | |
| 34 | Ownership | 171,602 | 34 |
| | C. Ancillary Expense | | |
| 35 | Special Cost Centers | | 35 |
| 36 | Provider Participation Fee | | 36 |
| | D. Other Expenses (specify): | | |
| 37 | | 232 | 37 |
| 38 | | | 38 |
| 39 | | | 39 |
| 40 | TOTAL EXPENSES (sum of lines 31 thru 39)* | \$ 2,187,611 | 40 |
| 41 | Income before Income Taxes (line 30 minus line 40)** | (8,878) | 41 |
| 42 | Income Taxes | | 42 |
| 43 | NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | \$ (8,878) | 43 |

| * | This mus | t agree with | page 4, | line 45, col | lumn 4. |
|---|----------|--------------|---------|--------------|---------|
|---|----------|--------------|---------|--------------|---------|

| * | Does this agree with t | axable income (loss) per Federal Income |
|---|------------------------|---|
| | Tax Return? | If not, please attach a reconciliation. |

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor East-Beardstown

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

| | | 1 | 2** | 3 | 4 | |
|----|-------------------------------|-----------|-----------|------------------|----------|----|
| | | # of Hrs. | # of Hrs. | Reporting Period | Average | |
| | | Actually | Paid and | Total Salaries, | Hourly | |
| | | Worked | Accrued | Wages | Wage | |
| 1 | Director of Nursing | 1,840 | 2,080 | \$ 42,938 | \$ 20.64 | 1 |
| 2 | Assistant Director of Nursing | | | 0 | | 2 |
| 3 | Registered Nurses | 5,809 | 6,049 | 125,522 | 20.75 | 3 |
| 4 | Licensed Practical Nurses | 9,198 | 9,663 | 146,403 | 15.15 | 4 |
| 5 | Nurse Aides & Orderlies | 37,227 | 39,649 | 372,286 | 9.39 | 5 |
| 6 | Nurse Aide Trainees | 100 | 100 | 941 | 9.41 | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | 1,717 | 1,922 | 19,198 | 9.99 | 8 |
| 9 | Activity Director | | | | | 9 |
| | Activity Assistants | 3,097 | 3,619 | 29,111 | 8.04 | 10 |
| 11 | Social Service Workers | 1,000 | 1,000 | 11,782 | 11.78 | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | | | | | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 13,445 | 14,488 | 110,016 | 7.59 | 15 |
| 16 | Dishwashers | | | | | 16 |
| 17 | Maintenance Workers | 1,814 | 2,060 | 25,580 | 12.42 | 17 |
| | Housekeepers | 7,668 | 8,105 | 53,519 | 6.60 | 18 |
| 19 | Laundry | 1,896 | 2,069 | 21,870 | 10.57 | 19 |
| 20 | Administrator | 1,900 | 2,080 | 56,810 | 27.31 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | | | | | 22 |
| 23 | Office Manager | | | | | 23 |
| 24 | Clerical | 4,699 | 5,251 | 49,143 | 9.36 | 24 |
| | Vocational Instruction | | | | | 25 |
| 26 | Academic Instruction | | | | | 26 |
| 27 | Medical Director | | | | | 27 |
| 28 | Qualified MR Prof. (QMRP) | | | | | 28 |
| 29 | Resident Services Coordinator | | | | | 29 |
| 30 | Habilitation Aides (DD Homes) | | | | | 30 |
| 31 | Medical Records | | | | | 31 |
| 32 | Other Health Care(specify) | | | | | 32 |
| | Other(specify) Beautician | | | | | 33 |
| 34 | TOTAL (lines 1 - 33) | 91,410 | 98,135 | s 1,065,119 * | \$ 10.85 | 34 |

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

| | | 1 | 2 | 3 | |
|----|---------------------------------|---------|------------------|------------|----|
| | | Number | Total Consultant | Schedule V | |
| | | of Hrs. | Cost for | Line & | |
| | | Paid & | Reporting | Column | |
| | | Accrued | Period | Reference | |
| 35 | Dietary Consultant | | s 0 | | 35 |
| 36 | Medical Director | | 500 | | 36 |
| 37 | Medical Records Consultant | | 1,035 | | 37 |
| 38 | Nurse Consultant | | | | 38 |
| 39 | Pharmacist Consultant | | 2,214 | | 39 |
| 40 | Physical Therapy Consultant | | | | 40 |
| 41 | Occupational Therapy Consultant | | | | 41 |
| 42 | Respiratory Therapy Consultant | | | | 42 |
| 43 | Speech Therapy Consultant | | | | 43 |
| 44 | Activity Consultant | | | | 44 |
| 45 | Social Service Consultant | | 2,544 | | 45 |
| 46 | Other(specify) | | | | 46 |
| 47 | | | | | 47 |
| 48 | | | | | 48 |
| | | | | | |
| 49 | TOTAL (lines 35 - 48) | | \$ 6,293 | | 49 |

C. CONTRACT NURSES

| | | 1 | 2 | 3 | |
|----|---------------------------|---------|----------|------------|----|
| | | Number | | Schedule V | |
| | | of Hrs. | Total | Line & | |
| | | Paid & | Contract | Column | |
| | | Accrued | Wages | Reference | |
| 50 | Registered Nurses | | \$ 0 | | 50 |
| 51 | Licensed Practical Nurses | | 13,563 | | 51 |
| 52 | Nurse Aides | | 0 | | 52 |
| 53 | TOTAL (lines 50 - 52) | | s 13,563 | | 53 |

^{**} See instructions.

| STATE | OF: | ILLINOIS | |
|-------|-----|----------|--|
|-------|-----|----------|--|

0041632 01/01/2004 Facility Name & ID Number Heritage Manor East-Beardstown **Report Period Beginning:** Ending: 12/31/2004 XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Description Name Function % Amount Amount Amount IDPH License Fee Pat McNeal 56,810 Workers' Compensation Insurance 40,383 **Unemployment Compensation Insurance** 16,575 Advertising: Employee Recruitment 2,030 FICA Taxes Health Care Worker Background Check 81,482 **Employee Health Insurance** 46,627 (Indicate # of checks performed 500 Employee Meals Central Office Allocation 2,609 Illinois Municipal Retirement Fund (IMRF)* Promotional Advertising 2,604 256 Public Relations 5,593 **Employee Hepatitis Vaccine** TOTAL (agree to Schedule V, line 17, col. 1) Employee Benefits -12,002 Dues and Subscriptions 5,213 (List each licensed administrator separately.) **Employee Benefits - central office** 24,752 License and Fees (842) 56,810 B. Administrative - Other Less: Public Relations Expense (5,593)Description Non-allowable advertising (1,107)Amount Yellow page advertising (2,604)TOTAL (agree to Schedule V, TOTAL (agree to Sch. V, 8,403 222,077 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar** (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount Vendor/Pavee Type Description Line# Amount Amount **Heritage Enterprises** Mgt Fees 135,682 **Out-of-State Travel** Robert McQuellen Consulting 1,500 0 In-State Travel 1,887 39 3,185 Seminar Expense (8,913)0 5,801 Legal-- Adj to Zero 703 0 **Entertainment Expense** TOTAL (agree to Schedule V, line 19, column 3) TOTAL (agree to Sch. V, (If total legal fees exceed \$2500 attach copy of invoices.) 137,885 TOTAL line 24, col. 8) 1,999

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^{*} Attach copy of IMRF notifications

^{**}See instructions.

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Report Period Beginning: 01/01/2004 **Ending:**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

| | (See instructions.) | | | | | | | | | | | | |
|----|---------------------|--------------|------------|--------|--------|--------|--------|-----------|--------------|----------------|--------|--------|--------|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| | | Month & Year | | | | | | Amount of | Expense Amor | tized Per Year | | | |
| | Improvement | Improvement | Total Cost | Useful | | | | | | | | | |
| | Type | Was Made | | Life | FY2001 | FY2002 | FY2003 | FY2004 | FY2005 | FY2006 | FY2007 | FY2008 | FY2009 |
| 1 | | | \$ | | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | |
| 18 | | | | | | | ĺ | | ĺ | | | | |
| 19 | | | | | | | | | | | | | |
| 20 | TOTALS | | \$ | | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |

| Facilit | y Name & ID Number Heritage Manor East-Beardstown | | OF ILLINOIS # 0041632 | Report Period Beginning: | 01/01/2004 | Ending: | Page 23 12/31/2004 |
|---------|--|------|--|---|--|--------------------------|-----------------------|
| XX G | ENERAL INFORMATION: | | | • | | | |
| | | (13) | | supplies and services which are of the Public Aid, in addition to the daily | | | |
| (2) | Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association | | in the Ancillary Se | ection of Schedule V? yes | _ | | |
| (3) | Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes | (14) | the patient census is a portion of the | building used for any function other listed on page 2, Section B? yes building used for rental, a pharmacy explains how all related costs were a | , day care, etc.) | For example If YES, atta | le, |
| (4) | Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? | (15) | Indicate the cost of on Schedule V. related costs? | | assified to employ meal income be the amount. \$ | een offset ag | ainst |
| (5) | Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? yes 7 years | (16) | Travel and Transp | ortation ncluded for out-of-state travel? | no | | |
| (6) | Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10 | | If YES, attach a | complete explanation. eparate contract with the Departmen | nt to provide me | | |
| (7) | Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation. | | program during c. What percent of | this reporting period. \$ all travel expense relates to transpo | | | |
| (8) | Are you presently operating under a sale and leaseback arrangement? no If YES, give effective date of lease. | | e. Are all vehicles times when not | stored at the nursing home during the in use? yes | • | | |
| (9) | Are you presently operating under a sublease agreement? YES xx NO |) | out of the cost re | commuting or other personal use of eport? yes ity transport residents to and fi | - | | |
| (10) | Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over. | 7, | Indicate the a | mount of income earned from no during this reporting period. | providing sucl \$ | h 5 | <u>no</u> |
| | | (17) | Firm Name: St | performed by an independent certifi llaski & Webb | | The instruc | tions for the |
| (11) | Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,077 This amount is to be recorded on line 42 of Schedule V. | | | that a copy of this audit be included no If no, please explain. | Not available | | |
| (12) | Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation. | | out of Schedule V | | | - | |
| | | (19) | performed been att | re in excess of \$2500, have legal intached to this cost report? d a summary of services for all arch | | - | rices |

| Acres (| | ot o | and the same | Tog Silke 4 pg | Chipamera | | | | |
|--------------------------|---|-------------------------------|--|----------------|-----------|--------------------------------------|--|---|-----------------------------|
| Ξ | CASE IN BOX CASE IN BOX CASE IN BOX PAYROLL | 14,007 | | | | 1 | LIMITATIVE MART | | |
| 100 | MEDICAN DICTIONS PARCON DICTIONS | NUMB | | | | Uni Uni Uni | LOT ACCUMINGWAY LOT ACCUMINGWAY LOT ACCUMINGWAY | | |
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